New America Foundation's
OPEN TECHNOLOGY INITIATIVE

USING EXISTING MEANS-TESTED BENEFITS PROGRAMS TO INSTRUCT A LIFELINE BROADBAND PILOT DESIGN

Presented as an addendum to our proposed Pilot Study Research Design Proposal ("Study Design") attached as Appendix A to the Public Interest Comments filed August 24, 2011, the following is a survey of existing pilot program designs. We believe these can be instructive for the Commission as it designs its own Lifeline Broadband Pilot, as proposed in the March 4th, 2011, *Notice of Proposed Rulemaking* (NPRM). Specifically, this document:

- Outlines resources and methods available for **establishment of baseline metrics** prior to implementation of a broadband pilot
- Identifies **successful data collection tools** used by other pilot programs

By focusing on community-wide effects of adoption in a context broader than individual subscription rates, and by using the metrics proposed here and in previous filings, the Commission can obtain clear, significant results that can instruct further broadband adoption and access policy for low-income communities.

I. EXISTING DATA SETS, DATA COLLECTION INSTRUMENTS, AND PILOT STUDIES

A. Use of Existing Data Sets to Assist in Selection of Sites and Sample Populations

Existing data can help identify target pilot sites and sample populations, as well as establish baseline demographics and other related variables, thus providing the Commission with a point of comparison for gauging effects of a pilot on rates and effects of broadband adoption. For example, such datasets may include:

- **Enrollment data for existing means-tested public benefits programs**: information on potential participants and methods through which to reach them.
    - The One-Stop Career Centers identified below, which already performed due diligence assessments of sites inhabited by chronically-underserved communities.[1]
- **Census data**: geolocated demographic information, which helps identify chronically-underserved communities, such as those whose high poverty levels, low educational attainment, high rates of linguistic isolation, age, *etc*... correlates to a lack of access to communications technologies.
- **Residential broadband subscription data**: (available from providers) could be compared with census data to target the "neediest" populations – those that lack

[1] One-Stop Career Centers offer low-wage workers support and resources for improving their careers, job prospects, and financial situations. Staff at the Centers offer assistance in career planning, resume writing, job searching, market trends, interviewing techniques, and other job-related skills. *See* http://wdr.doleta.gov/research/FullText_Documents/ETAOP_2011-16.pdf

economic means, access to physical infrastructure, or are subject to otherwise low levels of demand or supply of broadband service.

- **Telehealth, telemedicine, and E-rate grant disbursement data**: could allow the Commission to leverage existing data from other universal access programs, which it can then compare to census and subscription data in order to isolate the effects of access to such programs on broadband adoption.
- **BTOP and BIP grant disbursement data**: could be leveraged in similar ways as data relating to other universal access programs, in order to look at the effects of the presence of a social and community infrastructure on broadband adoption. Could also provide control groups to test effects of a pilot on communities that use BTOP-provided technology access points as compared to those that do not.

As we noted in our Study Design, any pilot the Commission develops should be applied in multiple locations with varying demographic and geographic characteristics in order to control for those factors and isolate their relevant effects.[2]

B. Reliance on Existing Data Collection Instruments

As we have noted here and previously, the definition of broadband adoption must be robust, and many data collection instruments developed by BTOP grant recipients can be reused for the purposes of a pilot study. For instance, qualitative and quantitative instruments designed by BTOP partners in Philadelphia and Detroit conceptualize adoption according to four categories:

- **Modality:** how participants access broadband
- **Uses:** what participants do when they go online
- **Relevance:** why broadband access is important and how its importance compares to other needs
- **Satisfaction:** whether participants are pleased with their training

Using both qualitative and quantitative data collection tools measuring each of these characteristics of adoption, the Commission can minimize the time, effort and costs needed to develop reliable, valid tools for obtaining a rich, textured understanding of how to define adoption. Further, a combination of these methods has greater explanatory value than the use of survey questions solely concerned with whether clients pay for a home broadband subscription.[3]

C. Example Pilot Studies Involving Means-Tested Programs

By drawing from the following three examples, the Commission can minimize time and resources spent on a Lifeline broadband pilot program. These examples represent innovative

[2] Comments of The Benton Foundation, The Open Technology Initiative at New America Foundation, Public Knowledge, United Church of Christ, The Center for Rural Strategies, Access Humboldt, and Deep Tech, WC Docket Nos. 11-42, 03-109, CC Docket No. 96-45, Appendix A at 6 (filed Aug. 24, 2011), where we noted that the use of nested studies, where multiple neighborhoods in one city might be selected and results compared among them, would enhance the effects of site variability.

[3] These characteristics are also adaptable. For instance, if the Commission chooses not to offer training in conjunction with a broadband subsidy, it can eliminate questions related to "satisfaction."

thinking in the delivery and evaluation of means-tested public benefits programs and include reliable and valid qualitative and quantitative metrics. In short, the Commission need not design an overly complex pilot evaluation in order to obtain interesting and meaningful results, and can instead rely on existing defensible methodologies.

Example 1: Work Advancement and Support Center (WASC) Demonstration[4]

WASC was a test program intended to build the capacity of the workforce and welfare systems to provide employment retention, work support, and advancement services to low-income workers. It was implemented through a series One-Stop Career Centers (the creation of such centers was established by the Workforce Investment Act). The pilot and evaluation were administered by the Manpower Demonstration Research Corporation ("MRDC"), a non-profit, nonpartisan, social policy research organization that focuses on the well-being of low-income populations.

Pilot Program Population:
Three demonstration sites:

- Dayton, Ohio (1,184 total participants)
- Bridgeport, Connecticut (706 total participants)
- San Diego, California (971 total participants)

Enrollment and Sampling Methods: MDRC recruited sample populations from One-Stop Career Centers (or One-Stop Service Centers), which feature a high concentration of eligible participants.

How Benefits were Disbursed: Participants assigned to test groups—i.e., participants who received WASC benefits in addition to gaining access to the usual set of benefits available at One-Stop Centers—interacted with trained career coaches who provided assistance to low-wage workers in keeping jobs, finding better jobs, and accessing work supports. These career coaches also helped increase ease of access to other social support programs such as Earned Income Tax Credit, child care subsidies, food stamps, and Medicaid.

Pilot Study Design and Evaluation of Pilot Program Effectiveness
Evaluation was conducted using a basic randomized control trial research design.

- MDRC used a lottery to assign low-income workers at the career centers to either a WASC test group or a control group that provided everything except for WASC services.
- MDRC also studied sub-groups (part-time workers, immigrants, dislocated workers and workers enrolled in school or training) from the test groups to give a more complete and accurate assessment of the effectiveness of the program
- Finally, MDRC relied on qualitative methods, which included interviews with staff, focus groups with recipients, and observation of trainings.

Example 2: New Hope Project[5]

[4] *See* http://www.mdrc.org/project_16_40.html.
[5] *See* http://www.mdrc.org/project_22_30.html and Greg Duncan, Cynthia Miller, Amy Classens, Mimi Engel, Heather Hill, Constance Lindsay, New Hope's Eight-Year Impacts on

The New Hope Project was launched by a community-based organization in Milwaukee and offered guaranteed income above the poverty level, as well as community service opportunities, health insurance, and child-care subsidies to poor people who were willing to work full time. Participants were given the option to choose the benefits they wanted rather than having to sign up for all of them.

Pilot Program Population: 1,357 individuals and 745 families in Milwaukee, Wisconsin[6]

Enrollment and Sampling Methods:

- Various outreach activities to identify and invite potential participants to a program orientation
- At orientation, explanation of program, eligibility criteria, and plans to study pilot program effectiveness
- Following orientation, meetings with interested participants to determine if they met eligibility criteria
- Upon qualification, administration of a baseline questionnaire to gather demographic and household data, employment and welfare history, and opinions about work and welfare
- Also, administration of randomized control trials where control group members were told that they could not be served by New Hope, but were given a list of other organizations where they could go for employment related help

How Benefits were Disbursed: Monthly disbursement by mail or in person of a supplement check to participants who had worked an average of at least 30 hours/week. Participants were required to report income and work history, which New Hope reviewed to determine the amount of the supplement.

Pilot Study Design and Evaluation of Pilot Effectiveness

Success of the program was assessed in terms of whether or not the test group experienced: increased rates of employment, increased income and reduced poverty, reduced use of welcome and other forms of public assistance, increased health insurance coverage, increased use of paid childcare, improved sense of well-being (material comfort, home environment, family stability, progress toward achieving personal goals).

Instruments included:

- In-person surveys administered immediately after the program's completion
- Surveys administered two and five years later to gauge the long-term effects of the program on the workers themselves and their children, if any
- Reliance on existing data sets (demographic and otherwise) in order to determine effectiveness of the program

Example 3: Healthy San Francisco

Employment and Family Income, MRDC Working Paper (July 2008) *available at* http://www.mdrc.org/publications/488/full.pdf ("2008 New Hope Working Paper").

[6] 2008 New Hope Working Paper at 12, Table 1.

HSF reaches out to individuals needing free or low-cost health care in San Francisco. Both academic researchers and evaluators have assessed the entire program (not just the initial pilot program). Mathematica authored the most recent comprehensive evaluation.

Pilot Program Population: Originally launched at two medical clinics with high concentrations of uninsured residents: Northeast Medical Services and Chinatown Public Health Center. At the time of publication, Mathematica reported an increase in enrollees from 7,930 to 95,580.

Enrollment and Sampling Methods: With no marketing or outreach budget, HSF developed an outreach strategy that relied on news articles, presentations, word of mouth, and recruitment by safety-net providers who made up a part of the program's group of medical homes. Pilot participants learned about the program through one of the listed outreach mechanisms, then made the decision to enroll when they came to one of the participating primary-care clinics.[7]

Because the clinics were open only during working hours, the program also launched a website to help potential enrollees determine whether they were eligible for the program and provided them with a list of medical homes in the city.

How Benefits are Disbursed: At each HSF medical home, staff members answered questions from potentially eligible adults, review application materials, and help them complete the program application. Program administrators used an application assistor program as it has had positive effects on a similar program in California's Healthy Families Program, and has been shown to shorten enrollment-to-medical-care times.

How Program Effectiveness is Evaluated

Mathematica's evaluation of HSF focused on four variables of interest: enrollment, satisfaction and access, utilization, and costs. The study sampled among enrollees and non-enrollees, triangulated those data sets with existing public health data sets, and used a mixture of qualitative and quantitative measures to study different groups of enrollees divided up by enrollment year, beginning with a pilot group in the first year. To understand the four variables, Mathematica:

- Used existing data on a similar program to establish a baseline rate of target enrollment
- Analyzed government data sets
- Administered pre- and post-enrollment surveys
- Conducted focus groups, interviews and observations to assess enrollment rates and retention rates

[7] *See* Margaret Colby, Catherine McLaughlin, Gregory Bee, Tricia Collins Higgins, Participation in Healthy San Francisco: Trends in Enrollment and Retention, Final Report at 35 (Feb. 28, 2011) *available at* http://www.healthysanfrancisco.org/files/PDF/Trends_in_Enrollment_and_Retention.pdf

Using this analysis, Mathematica found that the program has been highly effective in terms of enrollment, levels of satisfaction with the program, and actual utilization of primary care and preventative services.

II. IMPLICATIONS OF THESE PROGRAMS FOR A LIFELINE BROADBAND PILOT

These pilot programs and studies provide examples for ways the Commission can use existing social and community infrastructures and available information when designing, implementing, and evaluating a broadband pilot program. For example, the Commission could:

- **Recruit Lifeline Participants at One-Stop Service Centers:** Similar to the recruitment methods used by the WASC program, the Commission could use these centers to target low-wage workers who lack the time to go through the complicated process of applying for a separate set of benefits.
- **Coordinate with BTOP-Funded Public Computer Centers:** The New Hope Program contextualized the needs of the working poor broadly, recognizing that low-wage workers need not only supplemental income, but also health care, child care, and a general social support to lift participants above the poverty line. Similarly, the Commission should investigate the social support systems that add value to subsidies for residential broadband subscriptions; BTOP-funded public computer centers serve as examples of such support systems. A control-group study could examine whether subsidies are more effective in combination with other kinds of support. Using this method, the Commission could compare outcomes for participants who only receive a home broadband subsidy to those for populations who receive a subsidy but also gain access and training at a public computing center.
- **Rely on Established Community Institutions to Promote Broadband Pilot Participation:** Healthy San Francisco provides the Commission with an excellent model for enrollment strategies, relying on the existing infrastructure of public health centers to alert prospective enrollees about the program. These centers helped kickstart the program until other recruitment methods (such as HSF's online eligibility website) were in place and well-utilized, and also ensured that HSF serves the city's ethnically and linguistically diverse population. The Commission should rely on existing social and community infrastructures wherever possible to launch a broadband pilot program – for example, by turning to its own telehealth/telemedicine and E-rate programs to identify community institutions in order to promote enrollment in a broadband pilot.